Changes in Regulations from the 11/2/10 "Emergency MR/ID Waiver Regulations" to the 7/4/13 "Final ID Waiver Regulations"

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12VAC30-120-1000. Definitions		
1. "Mental Retardation/Intellectual Disability Waiver Regulations"	"Intellectual Disability Waiver Regulations"	Removal of the "R" word, per changes at the federal and state levels. Includes removal of term and abbreviation throughout the regulations.
2. Definition of Case Manager	Addition of "as either an employee or a contractor."	A case manager can either work for a CSB/BHA or be a contractor of those agencies.
3. Definition of Companion services	Addition of "routine" to "The provision of companion services does not entail routine hands-on care."	Recognition that there may be some limited situations in which a companion may have to assist an individual with occasional personal care tasks.
4.	New definition: "IDOLS means Intellectual Disability Online System"	New system for service authorization as of 2011.
5.	New definition: "In-home residential support services means support provided in a private residence by a DBHDS-licensed residential provider to an individual enrolled in the waiver to include: (i) skill building and supports and safety supports to enable individuals to maintain or improve their health; (ii) developing skills in daily living; (iii) safely using community resources; (iv) being included in the life of the community and home; (v) developing relationships; and (vi) participating as citizens of the community. In-home residential support services shall not replace the primary care provided to the	Clarification.

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	individual by his family and caregiver but shall be supplemental to it."	
6.	New definition: "Intellectual disability" or "ID" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) in the Intellectual Disability: Definition, Classification, and Systems of Supports (11th edition, 2010)."	Updated terminology. Replaces definition of "Mental retardation /intellectual disability. See #9 below.
7. ICF/MR	ICF/ID: Intermediate Care Facility for the Intellectually Disabled	Reflects new federal terminology.
8. Definition of "ISAR"	Deleted	Paper forms have migrated to on line system: IDOLS.
9. Definition of "Mental retardation/intellectual disability"	Deleted	Replaced by definition of Intellectual Disability. See. # 6 above.
10. Definition of "Prior Authorization"	Deleted	Replaced by definition of "Service Authorization." See #12 below.
11. Definition of "QMRP"	Changed to "the same as defined at 12VAC35-105-20."	Tying definition to DBHDS Licensing regulations definition.
12.	New definition: "Service authorization means the process of approving by either DMAS or its designated service authorization contractor, for the purpose of DMAS' reimbursement, the service for the individual before it is rendered."	Replaces definition of "Prior Authorization." See #10 above.
13. Definition of Services Facilitator	Changed from "ensuring the development and monitoring of the CD Services Plan for Supports" to "collaborating with the case manager to ensure the development and monitoring of the CD Services Plan for Supports."	Emphasis on collaboration with the individual's case manager.
12VAC30-120-1005. Waiver description and legal authority		

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14. D.3 MR/ID Waiver individuals who attain the age of six years of age, who are determined not to have a diagnosis of MR/ID, and who meet all Individual and Family Developmental Disability Support (IFDDS) Waiver eligibility criteria, shall be eligible for transfer to the IFDDS Waiver for the period of time up to their seventh birthday. Psychological evaluations confirming diagnoses must be completed less than one year prior to transferring to the IFDDS Waiver. These individuals transferring from the MR/ID Waiver will be assigned a slot in the IFDDS Waiver, subject to the approval of the slot by CMS. The case manager shall submit the current Level of Functioning Survey, Individual Support Plan and psychological evaluation (or standardized developmental assessment for children under six years of age) to DMAS for review. Upon determination by DMAS that the individual is appropriate for transfer to the IFDDS Waiver and there is a slot available for the child, the MR/ID case manager shall provide the family with a list of IFDDS Waiver case managers. The MR/ID case manager shall work with the selected IFDDS Waiver case manager to determine an appropriate transfer date and shall submit a DMAS-225 to the local DSS. The MR/ID waiver slot shall be held by the CSB until the child has successfully transitioned to the IFDDS waiver. Once the child's transition into the IFDDS waiver is	E.2. Individuals enrolled in the waiver who attain the age of six years of age, who are determined not to have a diagnosis of ID, and who meet all Individual and Family Developmental Disability Support (IFDDS) Waiver eligibility criteria, shall be eligible to apply for transfer to the IFDDS Waiver for the period of time up to their seventh birthday. Psychological evaluations or standardized development assessments confirming individuals' diagnoses must be completed less than one year prior to transferring to the IFDDS Waiver. These individuals transferring from the ID Waiver will be assigned a slot in the IFDDS Waiver, if one is available. The case manager shall submit the current Level of Functioning Survey, Individual Support Plan, and psychological evaluation (or standardized developmental assessment for children under six years of age) to DMAS for review. Upon determination by DMAS that the individual is appropriate for transfer to the IFDDS Waiver and there is a slot available for the child, the ID case manager shall provide the family with a list of IFDDS Waiver case managers. The ID case manager shall work with the selected IFDDS Waiver case manager to determine an appropriate transfer date and shall submit a DMAS-225 to the local department of social services. The ID Waiver slot shall be held by the CSB until the child has successfully	Addition of "to apply" in "shall be eligible to apply for transfer to the IFDDS Waiver. . ." Addition of "standardized developmental assessments" in lieu of psychological evaluations, if appropriate for the child based on age at the time of assessment for transfer (i.e., child is under six years of age when assessed). Replacement of DD waiver slot assignment "subject to the approval of the slot by CMS" with "if one is available." Deletion of the text, "If there is no IFDDS Waiver slot available for this child, then the child shall be placed on the IFDDS Waiver's waiting list. Such waiver individuals shall be disenrolled from the MR/ID Waiver."

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complete, the CSB shall reallocate, consistent with DBHDS guidance policies, the MR/ID slot to another individual on the waiting list. If there is no IFDDS waiver slot available for this child, then the child shall be placed on the IFDDS waiver's waiting list. Such waiver individuals shall be dis-enrolled from the MR/ID waiver.	transitioned to the IFDDS Waiver. Once the child's transition into the IFDDS Waiver is complete, the CSB shall reallocate the ID slot to another individual on the waiting list.	
12VAC30-120-1010. Individual eligibility requirements		
15. B. d. Services shall be recommended by the case manager based on a current assessment using a DBHDS-approved assessment instrument, as specified in DBHDS and DMAS guidance documents, by demonstrating need for each specific service;	B.4. Services shall be recommended by the case manager based on his documentation of the need for each specific service as reflected in a current assessment using a DBHDS-approved SIS instrument, or for children younger than five years of age, an alternative industry assessment instrument, such as the Early Learning Assessment Profile, and authorized by DBHDS.	Inclusion of the SIS as required assessment, with an alternative, appropriate assessment for children less than 5 years of age.
16. C.4. The case manager shall send the appropriate forms to DBHDS to enroll the individual in the MR/ID waiver or, if no slot is available, to place the individual on the waiting list. DBHDS shall only enroll the individual if a slot is available. If no slot is available, then the individual's name shall be placed on either the urgent or non-urgent statewide waiting list, consistent with criteria established in this waiver in 12VAC30-120-1088, until such time as a slot becomes available. Once notification has been received	C.4. The case manager shall enroll the individual in the Waiver or, if no slot is available, place the individual on the waiting list. The CSB shall only enroll the individual following electronic confirmation by DBHDS that a slot is available. If no slot is available, then the individual's name shall be placed on either the urgent or nonurgent statewide waiting list, consistent with criteria established in this waiver in 12VAC30-120-1088, until such time as a slot becomes available. Once the individual's name has been	Changes in the enrollment process due to the implementation of IDOLS.

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from DBHDS that the individual has been placed on either the urgent or non-urgent waiting list, the case manager shall notify the individual in writing within 10 business days of his placement on either list and offer appeal rights. The case manager shall contact the individual and the individual's family/caregiver, as appropriate, at least annually while the individual is on the waiting list to provide the choice between institutional placement and waiver services.	placed on either the urgent or nonurgent waiting list, the case manager shall notify the individual in writing within 10 business days of his placement on either list and offer appeal rights. The case manager shall contact the individual and the individual's family/caregiver, as appropriate, at least annually while the individual is on the waiting list to provide the choice between institutional placement and waiver services.	
17. D.1. Once the case manager has determined an individual meets the functional criteria for MR/ID waiver services, has determined that a slot is available, and that the individual has chosen MR/ID waiver services, the case manager shall submit enrollment information to DBHDS to confirm level of care eligibility and the availability of a slot.	D.1. Once the case manager has determined an individual meets the functional criteria for ID Waiver services, has determined that a slot is available, and that the individual has chosen ID Waiver services, the case manager shall submit enrollment information via the IDOLS to DBHDS to confirm level-of-care eligibility.	Changes in the enrollment process due to the implementation of IDOLS.
18. D.2. Once the individual has been enrolled by DBHDS, the case manager will submit a DMAS-225 along with a written confirmation from DBHDS of level of care eligibility, to the local DSS to determine financial eligibility for the waiver program and any patient pay responsibilities.	D. 2. Once the individual has been enrolled by the CSB, the case manager will submit a DMAS-225 along with a computer-generated confirmation of level-of-care eligibility to the local department of social services to determine financial eligibility for the waiver program and any patient pay responsibilities.	Changes in the DMAS-225 process due to the implementation of IDOLS.
19. D.3. After the case manager has received written notification of Medicaid eligibility by the local departments of social services and written confirmation of enrollment from DBHDS, the case manager shall so inform the individual and the individual's	D. 3. After the case manager has received written notification of Medicaid eligibility by the local departments of social services, the case manager shall so inform the individual and the individual's family/caregiver, as appropriate, to permit the development of	Removal of "written confirmation" of enrollment due to the changes caused by the implementation of IDOLS.

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family/caregiver, as appropriate, to permit the development of the Individual Support Plan.	the Individual Support Plan.	
20. D.3.a. The individual and the individual's family/caregiver, as appropriate, shall meet with the case manager within 30 calendar days to discuss the individual's needs and existing supports. . .	D.3.a. The individual and the individual's family/caregiver, as appropriate, shall meet with the case manager within 30 calendar days of waiver enrollment to discuss the individual's needs and existing supports. . .	Addition of "of waiver enrollment" in order to clarify the beginning of the 30 calendar day period.
21.	D.3.c. The individual enrolled in the waiver, or the family/caregiver as appropriate, and case manager must sign the ISP.	Addition to enhance clarity.
22. D. 4. The individual or case manager shall contact chosen service providers so that services can be initiated within 30 days of receipt of enrollment confirmation from DBHDS.	D. 4. The individual or case manager shall contact chosen service providers so that services can be initiated within 30 calendar days of enrollment.	Addition of "calendar" to clarify 30 days and removal of receipt of enrollment confirmation from DBHDS, per IDOLS.
23. D.5. The designated provider shall periodically monitor the DMAS-designated system for changes in patient pay obligations and adjust billing, as appropriate, with the change documented in the record in accordance with DMAS policy. When the designated collector of patient pay is the consumer-directed employer of record (EOR), the case manager shall forward a copy of the DMAS-225 form to the consumer-directed fiscal/employer agent and the EOR.	D.5. The designated provider shall monthly monitor the DMAS-designated system for changes in patient pay obligations and adjust billing, as appropriate, with the change documented in the record in accordance with DMAS policy. When the designated collector of patient pay is the consumer-directed personal or respite assistant or companion, the case manager shall forward a copy of the DMAS-225 form to the EOR along with the case manager's designation described in 12VAC30-120-1060 S 2 a (6). In such cases, the case manager shall be required to perform the monthly monitoring of the patient pay system and shall notify the EOR of all changes.	Clarification of frequency of expected provider monitoring of DMAS system for changes in patient pay obligations: monthly. Clarification that if the CD employee is collector of patient pay, the DMAS-225 must be sent to the EOR and the case manager must monitor the patient pay system monthly for any changes in the Patient Pay amount.
24. D.10. In the case of a waiver individual being referred back to a local department of social services for a re-determination of	D.10. In the case of an individual enrolled in the waiver being referred back to a local department of social services for a	Changes to the slot retention process due to the implementation of IDOLS.

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eligibility and in order to retain the designated slot, the case manager shall submit written information to DBHDS requesting retention of the designated slot pending the initiation of services. A copy of the request shall be provided to the individual and the individual's family/caregiver, as appropriate. DBHDS shall have the authority to approve the slot-retention request in 30-day extensions, up to a maximum of four consecutive extensions, or deny such request to retain the waiver slot for that individual. DBHDS shall provide a written response to the case manager indicating denial or approval of the slot extension request. DBHDS shall submit this response within 10 working days of the receipt of the request for extension and include the individual's right to appeal its decision.	redetermination of eligibility and in order to retain the designated slot, the case manager shall submit information to DBHDS requesting retention of the designated slot pending the initiation of services. A copy of the request shall be provided to the individual and the individual's family/caregiver, as appropriate. DBHDS shall have the authority to approve the slot-retention request in 30-day extensions, up to a maximum of four consecutive extensions, or deny such request to retain the waiver slot for that individual. DBHDS shall provide a response to the case manager indicating denial or approval of the slot extension request. DBHDS shall submit this response within 10 working days of the receipt of the request for extension and include the individual's right to appeal its decision.	
25. E.1.a. The Individual Support Plan, as defined herein, shall be developed annually by the case manager with the individual and the individual's family/caregiver, as appropriate, other service providers, consultants, and other interested parties based on relevant, current assessment data.	E.1.a. The Individual Support Plan, as defined herein, shall be collaboratively developed annually by the case manager with the individual and the individual's family/caregiver, as appropriate, other service providers, consultants, and other interested parties based on relevant, current assessment data.	Addition of the word "collaboratively."
26. E.2.b. At least every three years or when the individual's support needs change significantly, the case manager, with the assistance of the individual and other appropriate parties who have knowledge of the individual's circumstances and needs for	E.2.b. At least every three years for those individuals who are 16 years of age and older and every two years for those individuals who are ages birth through 15 years old, or when the individual's support needs change significantly, the case manager, with the	Clarification that the assessment must be completed at least every two years for individuals 15 years of age and younger and that an approved alternative assessment may be used for children under five years of age.

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support, shall complete the DBHDS-approved SIS form or its approved substitute form.	assistance of the individual and other appropriate parties who have knowledge of the individual's circumstances and needs for support, shall complete the DBHDS-approved SIS form or an approved alternative instrument for children younger than the age of five years.	
12VAC30-120-1020. Covered services; limits on covered services		
27.	A.5.c.(4) If the services facilitator initiates the involuntary disenrollment from consumer direction, then he shall inform the case manager.	Addition.
28. A.6. Coordination of waiver services with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid benefit. When the definition of this waiver's service is the same as that for EPSDT, then reimbursement for the waiver service shall first be made through the Medicaid EPSDT benefit.	A.6. All requests for this waiver's services shall be submitted to either DMAS or the service authorization contractor for service (prior) authorization.	Deletion of language about first requesting service through EPSDT due to change back to the original interpretation of seeking Waiver reimbursement first, EPSDT second.
Assistive Technology Service Description		
29. B.2.a. Effective July 1, 2011, the maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be $3,000 per calendar year for individuals regardless of waiver for which AT is approved. Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between	B.2.a. The maximum funded expenditure per individual for all AT covered procedure codes (combined total of AT items and labor related to these items) shall be $5,000 per calendar year for individuals regardless of waiver for which AT is approved. The service unit shall always be one for the total cost of all AT being requested for a specific timeframe.	Removed references to a $3,000.00 limit.

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July 1, 2011, and December 31, 2011, shall be subject to $3,000 annual maximum, and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. Expenditures made in the first six months of CY 2011 (under the $5,000 limit) shall count against the $3,000 limit applicable in the second six months of CY 2011. For subsequent calendar years, the limit shall be $3,000 throughout the time period. The service unit shall always be one, for the total cost of all AT being requested for a specific timeframe.		
30. B.4. Medical equipment and supplies required for individuals under age 21 that are covered both under the State Plan for Medical Assistance and outside the State Plan shall be furnished through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.	Deleted.	Change in EPSDT/Waiver combination interpretation.
Companion Services (AD & CD) Service Description		
31. C.3.b. A companion shall not be permitted to provide nursing care procedures such as, but not limited to, ventilators, continuous tube feedings, suctioning of airways, or wound care.	C.3.b. A companion shall not be permitted to provide nursing care procedures such as, but not limited to, ventilators, tube feedings, suctioning of airways, or wound care.	Deletion of the word "continuous" in relation to tube feedings.
Day Support Services Service Description		
32. E.4.a. This service shall be limited to 780 unit blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 seconds. If this service is used in combination	E.4.a. This service shall be limited to 780 blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 minutes. Two blocks are defined as four	Removal of reference to units in section about Day Support. Correction of time frame (seconds to minutes) and addition of definition of time frames for two blocks and three blocks.

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with prevocational or group supported employment services, or both, the combined total units for day support, prevocational or group supported employment services shall not exceed 780 units, or its equivalent under the DMAS fee schedule, per Individual Support Plan year.	hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes. If this service is used in combination with prevocational, or group supported employment services, or both, the combined total units for day support, prevocational, or group supported employment services shall not exceed 780 units, or its equivalent under the DMAS fee schedule, per Individual Support Plan year.	
Environmental Modifications Service Description		
33. F. This service shall be defined as those physical adaptations to the waiver individual's primary home or primary vehicle which shall be required by the waiver individual's Individual Support Plan, that are necessary to ensure the health and welfare of the individual, or which enable the individual to function with greater independence and without which the individual would require institutionalization . . . Environmental modifications reimbursed by DMAS may only be made to an individual's work site when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act.	F. This service shall be defined, as set out in 12VAC30-120-1000, as those physical adaptations to the individual's primary home, primary vehicle, or work site that shall be required by the individual's Individual Support Plan, that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence. Environmental modifications reimbursed by DMAS may only be made to an individual's work site when the modification exceeds the reasonable accommodation requirements of the Americans with Disabilities Act.	Service description made to conform to service definition in earlier section of the regulations. Removal of language about institutionalization, as this is the expectation for the waiver as a whole. Addition of language about modifications to work sites and placement of sentence about EM on work sites regarding ADA earlier in the paragraph.
34. F.2.a. Environmental modifications shall be provided in the least expensive manner possible that will accomplish the modification required by the waiver individual and shall be completed within the Plan of Support year consistent with such plan's requirements.	F.2.a. Environmental modifications shall be provided in the least expensive manner possible that will accomplish the modification required by the individual enrolled in the waiver and shall be completed within the calendar year consistent with the Plan of Supports' requirements.	Clarification that the Environmental Modification "year" is the calendar year vs. the Plan of Support year.

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35. F.2.a. Effective July 1, 2011, the maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be $3,000 per calendar year for individuals regardless of waiver for which EM is approved. Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to $3,000 annual maximum, and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. Expenditures made in the first six months of CY 2011 (under the $5,000 limit) shall count against the $3,000 limit applicable in the second six months of CY 2011. For subsequent calendar years, the limit shall be $3,000 throughout the time period. The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.	F.2.b. The maximum funded expenditure per individual for all EM covered procedure codes (combined total of EM items and labor related to these items) shall be $5,000 per calendar year for individuals regardless of waiver for which EM is approved. The service unit shall always be one, for the total cost of all EM being requested for a specific timeframe.	Removed references to a $3,000.00 limit.
36. F.2.a. EM shall be available to individuals who are receiving at least one other waiver service in addition to MR/ID targeted case management pursuant to 12 VAC 30-50-450.	F.2.b. EM shall be available to individuals enrolled in the waiver who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting.	Removed reference to targeted case management, as it is not a waiver service. Added clarification that EM may be provided in residential and nonresidential settings.
Prevocational Services Service Description		
37. I.2.a. This service shall be limited to 780 unit blocks, or its equivalent under the DMAS	I.2.a. This service shall be limited to 780 blocks, or its equivalent under the DMAS fee	Removal of reference to units in section about Prevocational services. Correction of time

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fee schedule, per Individual Support Plan year. If this service is used in combination with day support or group-supported employment services, or both, the combined total units for prevocational services, day support and group supported employment services shall not exceed 780 unit blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 seconds.	schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 minutes. Two blocks are defined as four hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes. If this service is used in combination with day support or group-supported employment services, or both, the combined total units for prevocational services, day support and group supported employment services shall not exceed 780 blocks, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59.	frame (seconds to minutes) and addition of definition of time frames for two blocks and three blocks. Addition of limit for combinations of Prevocational, Day Support and/or Group Supported Employment.
Residential Services Service Description		
38. J. Residential support services shall not be routinely reimbursed up to a 24-hour period.	J. Only in exceptional instances shall residential support services be routinely reimbursed up to a 24-hour period.	Clarification of language regarding reimbursement of services for a 24-hour period.
39.	J.1.e-f In-home residential supports shall be supplemental to the primary care provided by the individual, his family member or members, and other caregivers. In-home residential supports shall not replace this primary care. In-home residential supports shall be delivered on an individual basis, typically for less than a continuous 24-hour period. This service shall be delivered with a 1:1 staff-to-	Additional language to distinguish In-home Residential Supports from Congregate Residential Supports.

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	individual ratio except when skill building supports require interaction with another person.	
Respite Services (AD & CD) Services Description		
40. K.2. Respite services shall be those that are normally provided by the individual's family or other unpaid primary caregiver. These covered services shall be furnished on a short-term, episodic or periodic, basis because of the absence of the unpaid caregiver or need for relief of those unpaid caregiver or caregivers who normally provide care for the individual in order to prevent the breakdown of the unpaid caregiver.	K.2. Respite services shall be those that are normally provided by the individual's family or other unpaid primary caregiver. These covered services shall be furnished on a short-term, episodic, or periodic basis because of the absence of the unpaid caregiver or need for relief of the unpaid caregiver or caregivers who normally provide care for the individual	Deletion of "breakdown of the unpaid caregiver" language. Deemed unnecessary and potentially pejorative.
41. K.3.b. Respite services shall only be offered to individuals, in order to avoid institutionalization of the individual, who have an unpaid primary caregiver or caregivers who require temporary relief. Such need for relief may be either episodic or intermittent.	K.3.b. Respite services shall only be offered to individuals who have an unpaid primary caregiver or caregivers who require temporary relief. Such need for relief may be either episodic, intermittent, or periodic.	Removal of language about institutionalization, as this is the expectation for the waiver as a whole. Addition of "periodic" as a descriptor of the need for respite.
42. K.4.a. The unit of service shall be one hour. Respite services shall be limited to 720 hours per individual per calendar year, to be prior authorized in six-month increments not to exceed 360 hours per six months. If an individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 720 maximum limit shall be approved for payment. Individuals who do not use all of their allowed respite hours in the first six month-prior authorization period shall not be	K.4.a. The unit of service shall be one hour. Respite services shall be limited to 480 hours per individual per state fiscal year. If an individual changes waiver programs, this same maximum number of respite hours shall apply. No additional respite hours beyond the 480 maximum limit shall be approved for payment. Individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 480 hours per year combined.	Updating the annual respite limit from 720 hours per calendar year to 480 hours per fiscal year.

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permitted to carry over any unused portion of hours to the second prior authorization period. Individuals who are receiving respite services in this waiver through both the agency-directed and CD models shall not exceed 720 hours per calendar year combined.		
Services Facilitation and Consumer-Directed Service Model Service Description		
43.	L.3.c. This employer management training shall be completed before the individual or EOR may hire an assistant who is to be reimbursed by DMAS.	Replacement language for #48 below.
44. L.4. After the initial visit, the services facilitator shall continue to monitor the individual's Plan for Supports quarterly (i.e., every 90 days) and more often as-needed. If CD respite services are provided, the services facilitator shall review the utilization of CD respite services either every six months or upon the use of 100 respite services hours, whichever comes first.	L.4. After the initial visit, the services facilitator shall continue to monitor the individual's Plan for Supports quarterly (i.e., every 90 days) and more often as-needed. If CD respite services are provided, the services facilitator shall review the utilization of CD respite services either every six months or upon the use of 240 respite services hours, whichever comes first.	Change in Services Facilitator review of CD Respite services from upon the use of 100 hours to 240 hours (to equal ½ of annual limit).
45. L.10 If an individual enrolled in consumer-directed services has a lapse in services facilitator duties for more than 90 consecutive days, and the individual or family/caregiver is not willing or able to assume the service facilitation duties, then the case manager shall notify DMAS or its designated prior authorization contractor and the consumer-directed services shall be discontinued. The individual shall be given his choice of an agency for the alternative personal care, respite or companion services that he was	L.10. If an individual enrolled in consumer-directed services has a lapse in services facilitator duties for more than 90 consecutive days, and the individual or family/caregiver is not willing or able to assume the service facilitation duties, then the case manager shall notify DMAS or its designated prior authorization contractor and the consumer-directed services shall be discontinued once the required 10 days notice of this change has been observed. The individual whose consumer-directed services have been	Addition of language regarding observation of the required 10 days notice prior to discontinuing services and reminder of the individual's right to appeal.

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previously obtaining through consumer direction.	discontinued shall have the right to appeal this discontinuation action pursuant to 12VAC30-110. The individual shall be given his choice of an agency for the alternative personal care, respite, or companion services that he was previously obtaining through consumer direction.	
46. L.11. The CD services facilitator, who is to be reimbursed by DMAS, shall not be the waiver individual, the individual's case manager, a direct service provider, the individual's spouse, or parent of the individual who is a minor child**,** or a family/caregiver who is employing the assistant/companion.	L.11. The CD services facilitator, who is to be reimbursed by DMAS, shall not be the individual enrolled in the waiver, the individual's case manager, a direct service provider, the individual's spouse, a parent of the individual who is a minor child, or the EOR who is employing the assistant/companion.	Change of language of persons prohibited from being a Services Facilitator from "a family/caregiver" to "the EOR."
47. L.14.b. A waiver individual who is younger than 18 years of age shall be required to have someone function in the capacity of an EOR.	L.14.b. An individual enrolled in the waiver who is younger than 18 years of age shall be required to have an adult responsible for functioning in the capacity of an EOR.	Clarification that the EOR for individuals under 18 years of age desiring to have Consumer Directed services must be an adult.
48. L.14.d. Once the individual is authorized for CD services, the individual or the EOR shall successfully complete management training conducted by the services facilitator using DMAS guidance documents before the individual may hire an assistant for Medicaid reimbursement.	Deleted.	Replaced by guidance in #43 above.
Skilled Nursing Services Description		
49. M.2. The services shall be explicitly detailed in a Plan for Supports and shall be specifically ordered by a physician as medically necessary to prevent institutionalization.	M.2. The services shall be explicitly detailed in a Plan for Supports and shall be specifically ordered by a physician as medically necessary.	Removal of language regarding preventing institutionalization, as this is the expectation for the waiver as a whole.

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Supported Employment Services Service Description		
50. N. These services shall consist of intensive, ongoing supports that enable individuals to be employed in a regular work setting and may include assisting the individual to locate a job or develop a job on behalf of the individual, as well as activities needed to sustain paid work by the individual including skill-building, supports and safety supports on a job site. These services shall be provided in work settings where persons without disabilities are employed. It is especially designed for individuals with developmental disabilities, including individuals with MR/ID, who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential (i.e., individual's ability to perform work).	N. These services shall consist of ongoing supports that enable individuals to be employed in an integrated work setting and may include assisting the individual to locate a job or develop a job on behalf of the individual, as well as activities needed to sustain paid work by the individual including skill-building supports and safety supports on a job site. These services shall be provided in work settings where persons without disabilities are employed. Supported employment services shall be especially designed for individuals with developmental disabilities, including individuals with ID, who face severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential (i.e., the individual's ability to perform work).	Removal of the word "intensive" to describe supports provided by Supported Employment and replacement of the word "regular" with "integrated" to describe the desired work setting
51. N.2.a. Individual supported employment shall be defined as intermittent support, usually provided one-on-one by a job coach to an individual in a supported employment position.	N.2.a. Individual supported employment shall be defined as support, usually provided one-on-one by a job coach to an individual in a supported employment position.	Deletion of the word "intermittent" to describe the type of support provided by Supported Employment.
52. N.3.a. Only job development tasks that specifically include the individual shall be allowable job search activities under the MR/ID waiver supported employment service and DMAS shall cover this service only after determining that this service is not available from DRS for this waiver individual.	N.3.a. Only job development tasks that specifically pertain to the individual shall be allowable activities under the ID Waiver supported employment service and DMAS shall cover this service only after determining that this service is not available from DRS for this individual enrolled in the waiver.	Replaced the word "include" with "pertain to," permitting Supported Employment job development activities that do not involve being in the presence of the individual. Deleted "job search."
53. N.4.d. Group supported employment shall	N.4.d. Group supported employment shall be	Removal of reference to units regarding Group

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be limited to 780 unit blocks per individual**,** or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 seconds. If this service is used in combination with prevocational and day support services, the combined total unit blocks for these three services shall not exceed 780 units, or its equivalent under the DMAS fee schedule, per Individual Support Plan year.	limited to 780 blocks per individual, or its equivalent under the DMAS fee schedule, per Individual Support Plan year. A block shall be defined as a period of time from one hour through three hours and 59 minutes. Two blocks are defined as four hours to six hours and 59 minutes. Three blocks are defined as seven hours to nine hours and 59 minutes. If this service is used in combination with prevocational and day support services, the combined total unit blocks for these three services shall not exceed 780 units, or its equivalent under the DMAS fee schedule, per Individual Support Plan year.	Supported Employment. Correction of time frame (seconds to minutes) and addition of definition of time frames for two blocks and three blocks. Addition of limit for combinations of Prevocational, Day Support and/or Group Supported Employment.
Therapeutic Consultation Services Service Description		
54. O.1.b. Therapeutic consultation services shall not include direct therapy provided to waiver individuals or monitoring activities and shall not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.	O.1.b. Therapeutic consultation services shall not include direct therapy provided to individuals enrolled in the waiver and shall not duplicate the activities of other services that are available to the individual through the State Plan for Medical Assistance.	Removal of language prohibiting consultants from monitoring the results of their support plan.
55. O.3. Only behavioral consultation in this Therapeutic Consultation service may be offered in the absence of any other waiver service when the consultation is determined to be necessary to prevent institutionalization.	O.3. Only behavioral consultation in this therapeutic consultation service may be offered in the absence of any other waiver service when the consultation is determined to be necessary.	Removal of language regarding preventing institutionalization, as this is the expectation for the waiver as a whole.
12VAC30-120-1040. General requirements for participating providers		
56. A. Requests for participation shall be screened by DMAS or its designated contractor to determine whether the provider applicant meets the basic requirements for	A. Requests for participation as Medicaid providers of waiver services shall be screened by DMAS or its designated contractor to determine whether the provider applicant	Clarifying language regarding provider enrollment added to the end of this paragraph.

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provider participation.	meets the basic requirements for provider participation. All providers must be currently enrolled with DMAS in order to be reimbursed for services rendered. Providers who are not enrolled shall not be reimbursed. Consumer-directed assistants shall not be considered Medicaid providers for the purpose of enrollment procedures.	
57. C.17. Perform criminal history record checks for barrier crimes, as herein defined, within 15 days from the date of employment.	C.17. Perform criminal history record checks for barrier crimes, as defined in 12VAC30-120-1000, within 15 days from the date of employment.	Addition of the Virginia Administrative Code reference for definition section of these regulations. See "barrier crimes" definition for VAC reference for those crimes.
58. C.18. Refrain from performing any type of direct marketing activities to Medicaid recipients	C.18. Refrain from performing any type of direct marketing activities, as defined in 12VAC30-120-1000, to Medicaid individuals;	Addition of the Virginia Administrative Code reference for definition section of these regulations. See "direct marketing" definition for understanding of that term.
59.	C.20 Participate, as may be requested, in the completion of the DBHDS-approved assessment instrument when the provider possesses specific, relevant information about the individual enrolled in the waiver.	Addition of a requirement that all ID Waiver providers to participate, as requested, in the completion of the Supports Intensity Scale (or other appropriate assessment for children less than 5 years of age).
60. D. DMAS shall be responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS' policies and periodically re-certify each provider for participation agreement renewal to provide home and community-based waiver services.	D. DMAS or its contractor shall be responsible for assuring continued adherence to provider participation standards. DMAS or its contractor shall conduct ongoing monitoring of compliance with provider participation standards and DMAS' policies and periodically recertify each provider for participation agreement renewal to provide home and community-based waiver services.	Added "or its contractor" as another party that may ensure providers' continued adherence to and compliance with provider participation standards.
61. F. Providers shall use the required forms to document services, for purposes of reimbursement, to waiver individuals. The	F. Providers shall be required to use IDOLS to document services, for purposes of reimbursement, to individuals enrolled in the	Addition of requirement to use IDOLS as a means of documenting approved services for verification of appropriateness of

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DBHDS approved assessment shall be the Supports Intensity Scale (SIS), as published by the American Association on Intellectual and Developmental Disabilities and as may be amended from time to time, or its required successor form. Such forms shall be further described and discussed in the agency's guidance documents for this waiver program. 1. The Supports Intensity Scale form's use shall be phased-in across all CSBs/BHAs with completion effective by July 2012. During the phase-in process, CSBs/BHAs may use alternative assessment forms with the approval of DBHDS. 2. This provision for the phase-in process of the use of the SIS shall sunset effective July 1, 2012, except if otherwise noted in agency guidance documents.	waiver. The DBHDS approved assessment shall be the Supports Intensity Scale (SIS), as published by the American Association on Intellectual and Developmental Disabilities and as may be amended from time to time.	reimbursement. Removal of successor language regarding the SIS. Removal of phase in language regarding the SIS, as the period of phase in has passed.
62. H.1.(b) DBHDS shall review and approve, deny, or suspend for additional information, the requested change or changes to the individual's Plan for Supports. DBHDS shall communicate its determination to the case manager within 10 business days of receiving all supporting documentation regarding the request for change or in the case of an emergency, within three working days of receipt of the request for change.	H.1.(b) DBHDS shall review and approve, deny, or suspend for additional information, the requested change or changes to the individual's Plan for Supports. DBHDS shall communicate its determination to the case manager within 10 business days of receiving all supporting documentation regarding the request for change or in the case of an emergency within three business days of receipt of the request for change.	Change from "working" days to "business" days (for sake of consistency) in reference to service authorization staff response to emergency requests.
63. H.4. In an emergency situation when the health, safety, and welfare of the waiver	H.4. In an emergency situation when the health, safety, or welfare of	Changed "and" to "or" in "health, safety or welfare."

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individual, other individuals in that setting, or provider personnel are endangered, the case manager and DBHDS shall be notified prior to discontinuing services. The 10 business day written notification period shall not be required. The local DSS adult protective services or child protective services, as appropriate, and DBHDS Offices of Licensing and Human Rights shall be notified immediately when the individual's health, safety, and welfare may be in danger.	the individual enrolled in the waiver, other individuals in that setting, or provider personnel are endangered, the case manager and DBHDS shall be notified prior to discontinuing services. The 10-business-day prior written notification period shall not be required. The local department of social services adult protective services unit or child protective services unit, as appropriate, and DBHDS Offices of Licensing and Human Rights shall be notified immediately by the case manager and the provider when the individual's health, safety, or welfare may be in danger.	Addition of the word "prior" to clarify that typically 10 business days prior notification is required, but does not apply in emergency situations.
12VAC30-120-1060. Participation standards for provision of services; providers' requirements		
Documentation Requirements for Residential, Day Support, Supported Employment, and Prevocational Services		
64. A.1. A completed copy of the DBHDS-approved SIS assessment form, its approved alternative form during the phase in period, or its successor form as specified in DBHDS guidance documents.	A.1. A completed copy of the DBHDS-approved SIS assessment form or its approved alternative form during the phase in period.	Deletion of reference to successor form of the SIS. [phase in period language will be removed in the next version]
65. A.3. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with the individual and the individual's family/caregiver, as appropriate.	A.3. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate.	Addition of indication that changes to the Plan for Supports at any time must be agreed to by the individual and individual's family/caregiver, as appropriate.
Documentation Requirements for Personal Assistance, Respite, Companion		
66. B. The required documentation for personal assistance services, respite services, and companion services shall be as follows.	B. The required documentation for personal assistance services, respite services, and companion services shall be as set out in this	Replacement of "service authorization" for "prior authorization."

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The agency provider holding the service prior authorization or the services facilitator shall maintain records regarding each individual who is receiving services.	subsection. The agency provider holding the service authorization or the services facilitator, or the EOR in the absence of a services facilitator, shall maintain records regarding each individual who is receiving services.	Addition of the Employer of Record (EOR) as the responsible party for records maintenance in the absence of a services facilitator for those receiving CD PA, Respite or Companion.
67. B.1. A copy of the completed DBHDS-approved SIS assessment (or its approved alternative during the phase in period or its required successor form as specified in DBHDS guidance documents) and, as needed, an initial assessment completed by the supervisor or services facilitator prior to or on the date services are initiated;	B.1. A copy of the completed DBHDS-approved SIS assessment (or its approved alternative during the phase in period) and, as needed, an initial assessment completed by the supervisor or services facilitator prior to or on the date services are initiated.	Deletion of reference to successor form of the SIS.
68. B.3. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with the individual and the individual's family/caregiver, as appropriate.	B.3. For the annual review and in cases where the Plan for Supports is modified, the Plan for Supports shall be reviewed with and agreed to by the individual enrolled in the waiver and the individual's family/caregiver, as appropriate.	Addition of indication that changes to the Plan for Supports at any time must be agreed to by the individual and individual's family/caregiver, as appropriate.
69.	B.7. Documentation provided by the case manager as to why there are no providers other than family members available to render respite assistant care if this service is part of the individual's Plan for Supports.	Addition.
Documentation Requirements for AT, EM, PERS		
70. C.1. The appropriate Individualized Service Authorization Request (ISAR) form, to be completed by the case manager, may serve as the Plan for Supports for the provision of AT, EM, and PERS services. A rehabilitation engineer may be involved for AT or EM services if disability expertise is required that	C.1. The appropriate IDOLS documentation, to be completed by the case manager, may serve as the Plan for Supports for the provision of AT, EM, and PERS services. A rehabilitation engineer may be involved for AT or EM services if disability expertise is required that a general contractor may not have. The Plan	Replacing [paper] ISAR references with IDOLS references.

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a general contractor may not have. The Plan for Supports/ISAR shall include justification and explanation that a rehabilitation engineer is needed, if one is required. The ISAR shall be submitted to the state-designated agency or its contractor in order for prior authorization to occur;	for Supports/IDOL shall include justification and explanation that a rehabilitation engineer is needed, if one is required. The IDOL shall be submitted to the state-designated agency or its contractor in order for service authorization to occur;	
Documentation Requirements for Companion Services (AD & CD)		
71. E.4.a. For CD companion services, the case manager shall determine and document why no other providers are available.	Deleted.	Intent was to incorporate into 1060 B for all three CD services. Will correct in next version.
72. E.8.(3) Documentation of all employee management training provided to the waiver individual and the individual's family/caregiver, as appropriate, including the individual's and the individual's family/caregiver's, as appropriate, receipt of training on their responsibility for the accuracy of the companion's timesheets;	E.8.c. Documentation of all employer management training provided to the individual enrolled in the waiver or the EOR, including the individual's and the EOR's, as appropriate, receipt of training on their legal responsibility for the accuracy and timeliness of the companion's timesheets;	Replacement of "the individual's family/caregiver" with the EOR as recipient of employer management training. Addition of the word "legal" in relation to the employer's responsibility for properly completed timesheets.
Documentation Requirements for Crisis Stabilization		
73. F.2. The provider shall employ or use QMRPs, licensed mental health professionals or other qualified personnel who have demonstrated competence to provide crisis stabilization and related activities to individuals with MR/ID who are experiencing serious psychiatric or behavioral problems. The QMRP shall have: (i) at least one year of documented experience working directly with individuals who have MR/ID or developmental disabilities; (ii) at least either a bachelor's degree in a human services field including, but not limited to, sociology, social work, special	F.2. The provider shall employ or use QMRPs, licensed mental health professionals, or other qualified personnel who have demonstrated competence to provide crisis stabilization and related activities to individuals with ID who are experiencing serious psychiatric or behavioral problems.	Deletion of qualification requirements for QMRPs, as the definition references qualifications spelled out in 12VAC35-105-20.

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education, rehabilitation counseling, or psychology, or a bachelor's degree in another field in addition to an advanced degree in a human services field; and (iii) the required Virginia or national license, registration, or certification in accordance with his profession;		
Documentation Requirements for Personal Assistance Services (AD & CD)		
74. I.1. All personal assistants shall pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS which must be administered according to DBHDS' defined procedures.	I.1. All agency-directed personal assistants shall pass an objective standardized test of skills, knowledge, and abilities approved by DBHDS that must be administered according to DBHDS' defined procedures.	Clarification that this requirement is for agency-directed personal assistance employees only.
75. I.5.	I.5. All changes that are indicated for an individual's Plan for Supports shall be reviewed with and agreed to by the individual and, if appropriate, the family/caregiver.	Additional sentence added for clarification that changes to the Plan for Supports at any time must be agreed to by the individual and individual's family/caregiver, as appropriate.
76. I.8.d. Be willing to attend training at the waiver individual's and the family/caregiver's, and EOR's, as appropriate, request	I.8.d. Be willing to attend training at the individual's and EOR's, as appropriate, request	Deletion of "the family/caregiver" as a requestor of CD employee's attendance at training. This is to be requested by the individual and the EOR.
77. I.10.a. Payment shall not be made for services furnished by other family members living under the same roof as the waiver individual receiving services unless there is objective written documentation as to why there are no other providers available to render the services required by the waiver individual. The case manager shall make and document this determination.	I.10.a. Payment shall not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation completed by the services facilitator, or the case manager when the individual does not select services facilitation, as to why there are no other providers available to render the services.	Addition of clarification that the written documentation regarding family members as providers of CD Personal Assistance must come from the services facilitator or the case manager if there is no services facilitator.
Documentation Requirements for Prevocational Services		
78. K.3. Documentation confirming the	K.3. Preparation and maintenance of	Addition of the words "Preparation and

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individual's attendance and amount of time in services and specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. An attendance log or similar document must be maintained that indicates the individual's name, date, type of services rendered, staff signature and date, and the number of service units delivered, in accordance with the DMAS fee schedule. K.4. Documentation indicating whether the services were center-based or noncenter-based shall be included on the Plan for Supports. K.7 Documentation indicating that prevocational services are not available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA).	documentation confirming the individual's attendance and amount of time in services and specific information regarding the individual's response to various settings and supports as agreed to in the Plan for Supports. An attendance log or similar document must be maintained that indicates the individual's name, date, type of services rendered, staff signature and date, and the number of service units delivered, in accordance with the DMAS fee schedule. K.4. Preparation and maintenance of documentation indicating whether the services were center-based or noncenter-based shall be included on the Plan for Supports. K.7. Preparation and maintenance of documentation indicating that prevocational services are not available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA).	maintenance of" to each of these sections to clarify documentation expectations.
Documentation Requirements for Respite Services (AD & CD)		
79. M.6.a. When respite services are not received on a routine basis, but are episodic in nature, the supervisor or services facilitator shall conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite period. The supervisor or	M.6.a. When respite services are not received on a routine basis, but are episodic in nature, the supervisor or services facilitator shall conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite service authorization period. The	Addition of "service authorization" to clarify the period of time in which the supervisor or services facilitator must make the second home visit. Change in the interval at which the supervisor/services facilitator must review the

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services facilitator, as appropriate, shall review the use of respite services either every six months or upon the use of 100 respite service hours, whichever comes first.	supervisor or services facilitator, as appropriate, shall review the use of respite services either every six months or upon the use of 240 respite service hours, whichever comes first.	use of respite service hours from at 100 to 240 hours used.
80. M.9.b. Assistants shall have a satisfactory work record, as evidenced by one reference from prior job experiences including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children.	M.9.b. Assistants shall have a satisfactory work record, as evidenced by two references from prior job experiences including no evidence of possible abuse, neglect, or exploitation of any person regardless of age or disability	Change in requirement: respite assistants must have two (vs. one) references from prior job experiences. Person-centered change in language removing the word "incapacitated."
81. M.11 Assistants to be paid by DMAS shall not be the parents of waiver individuals who are minors or the individuals' spouses. Payment shall not be made for services furnished by other family members living under the same roof as the waiver individual who is receiving services unless there is objective written documentation as to why there are no other providers available to render the services required by the waiver individual. The case manager shall make and document this determination. Family members who are approved to be reimbursed for providing this service shall meet the same qualifications as all other respite assistants.	M.11. Assistants to be paid by DMAS shall not be the parents of individuals enrolled in the waiver who are minor children or the individuals' spouses. Payment shall not be made for services furnished by other family members living under the same roof as the individual who is receiving services unless there is objective written documentation completed by the services facilitator, or the case manager when the individual does not select services facilitation, as to why there are no other providers available to render the services required by the individual. Family members who are approved to be reimbursed for providing this service shall meet the same qualifications as all other respite assistants.	For those receiving CD Respite, the Services Facilitator must document the appropriateness of a family member living under the same roof as the individual to be service provider. If there is no Services Facilitator, the Case Manager completes this documentation.
Documentation Requirements for Skilled Nursing Services		
82. O.2. Skilled nursing services providers shall not be the parents (natural, adoptive, or foster) of waiver individuals who are minors or the waiver individual's spouse nor shall such	O.2. Skilled nursing services providers shall not be the parents (natural, adoptive, or foster) of individuals enrolled in the waiver who are minor children or the individual's	Correction: removal of language precluding skilled nursing providers from being employees of skilled nursing companies.

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persons be the employees of companies that render skilled nursing care to the waiver individual.	spouse	
83. O.5. Skilled nursing services may be ordered but shall not be provided simultaneously with respite care or personal care services.	O.5. Skilled nursing services may be ordered but shall not be provided simultaneously with respite or personal assistance services.	Correction of service names to Respite services and Personal Assistance services.
Documentation Requirements for Therapeutic Consultation		
84. Q.4. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and shall be forwarded to the case manager. If the consultation service extends beyond one year, the Plan for Supports shall be reviewed by the provider with the individual, and family/caregiver as appropriate, and the case manager, and this written annual review shall be submitted to the case manager, at least annually, or more often as needed. All changes to the Plan for Supports shall be reviewed with the individual and the individual's family/caregiver, as appropriate.	Q.4. If the consultation services extend three months or longer, written quarterly reviews are required to be completed by the service provider and shall be forwarded to the case manager. If the consultation service extends beyond one year or when there are changes to the Plan for Supports, the Plan shall be reviewed by the provider with the individual and family/caregiver, as appropriate. The Plan for Supports shall be agreed to by the individual and family/caregiver, as appropriate, and the case manager and shall be submitted to the case manager. All changes to the Plan for Supports shall be reviewed with and agreed to by the individual and the individual's family/caregiver, as appropriate.	Addition of requirement that the Therapeutic Consultation Plan for Supports be reviewed with and agreed to by the individual and family/caregiver, as appropriate, when there are changes to the plan.
Case manager's responsibilities for the Medicaid Long-Term Care Communication Form (DMAS-225)		
85. S.2.a.(6) When a service provider is designated by the case manager to collect the patient pay amount, a copy of the case manager's written designation, as specified in 12VAC 30-120-1010 (D)(5), and documentation of monthly monitoring of DMAS-designated system.	S.2.f. When a service provider or consumer-directed personal or respite assistant or companion is designated by the case manager to collect the patient pay amount, a copy of the case manager's written designation, as specified in 12VAC30-120-1010 D 5, and documentation of monthly monitoring of DMAS-designated system.	Addition of CD personal assistant, respite assistant or companion as a designated collector of patient pay.

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86. S.2.c. An individual's case manager shall not be the direct staff person or the immediate supervisor of a staff person who provides MR/ID Waiver services for the individual.		Deleted at this location. Case management regulation vs. waiver regulation.
12VAC30-120-1070. Payment for services		
87. A. All residential support, day support, supported employment, personal assistance (both agency-directed and consumer directed), respite (both agency-directed and consumer-directed), skilled nursing, therapeutic consultation, crisis stabilization, prevocational services, PERS, companion (both agency-directed and consumer directed), consumer-directed services facilitation, and transition services provided in this waiver shall be reimbursed consistent with the agency's service limits and payment amounts as set out in the fee schedule.	A. All residential support, day support, personal assistance (both agency-directed and consumer directed), respite (both agency-directed and consumer-directed), skilled nursing, therapeutic consultation, crisis stabilization, prevocational, PERS, companion (both agency-directed and consumer directed), consumer-directed services facilitation, and transition services provided in this waiver shall be reimbursed consistent with the agency's service limits and payment amounts as set out in the fee schedule.	Deleted supported employment from this list. See #88 below.
88.	B. Reimbursement rates for individual supported employment shall be the same as set by the Department for Aging and Rehabilitative Services for the same procedures. Reimbursement rates for group supported employment shall be as set by DMAS.	New addition per legislation that aligned individual supported employment rates with the DARS reimbursement rates for individual providers.
89. B. All AT and EM covered procedure codes provided in the MR/ID waiver shall be reimbursed as a service limit of one. Effective July 1, 2011, the maximum Medicaid funded expenditure per individual for all AT/EM	C. All AT and EM covered procedure codes provided in the ID Waiver shall be reimbursed as a service limit of one. The maximum Medicaid funded expenditure per individual for all AT/EM covered procedure codes	Deletion of all references to a $3,000 limit for AT and EM.

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covered procedure codes (combined total of AT/EM items and labor related to these items) shall be $3,000 per calendar year. No additional mark-ups, such as in the durable medical equipment rules, shall be permitted. Requests made for reimbursement between January 1, 2011, and June 30, 2011, shall be subject to a $5,000 annual maximum; requests made for reimbursement between July 1, 2011, and December 31, 2011, shall be subject to the $3,000 annual maximum, and shall consider, against the $3,000 limit, any relevant expenditure from the first six months of the calendar year. For subsequent calendar years, the limit shall be $3,000 throughout the period.	(combined total of AT/EM items and labor related to these items) shall be $5,000 each for AT and EM per calendar year. No additional mark-ups, such as in the durable medical equipment rules, shall be permitted.	
90. C.1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the ADA (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973, or the Virginians with Disabilities Act.	D.1. DMAS shall not duplicate services that are required as a reasonable accommodation as a part of the ADA (42 USC §§ 12131 through 12165), the Rehabilitation Act of 1973, the Virginians with Disabilities Act, or any other applicable statute.	Addition of language to prohibit duplication of services required by any applicable statute.
12VAC30-120-1080. Utilization review; level of care reviews		
91. B. Quality management reviews (QMR) shall be performed at least annually by DMAS Division of Long Term Care Services. Utilization review of rendered services shall be conducted by DMAS Division of Program Integrity (PI) or its designated contractor.	B. Quality management reviews (QMR) shall be performed by DMAS Division of Long Term Care Services or its designated contractor. Utilization review of rendered services shall be conducted by DMAS Division of Program Integrity (PI) or its designated contractor.	Deletion of expectation for annual quality management reviews. Addition of possibility of QMRs to be performed by DMAS designated contractor.
12VAC30-120-1088. Waiver waiting list		

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92. B. Urgent waiting list criteria. When a slot becomes available, the CSB/BHA shall determine, from among the waiver applicants included in the urgent category list, who shall be served first based on the needs of those applicants and consistent with these criteria. This determination shall be based on statewide criteria as specified in DBHDS guidance documents.	B. Urgent waiting list criteria. When a slot becomes available, the CSB/BHA shall determine, from among the applicants for enrollment in the waiver included in the urgent category list, who shall be served first based on the needs of those applicants and consistent with these criteria. This determination of the assignment of the slot shall be based on statewide criteria as specified in DBHDS guidance document entitled MR/ID Waiver Slot Assignment Process (rev 08/20/2010).	Addition of "assignment of the slot" for clarification and addition of reference to DBHDSA slot assignment guidance document.
93. B.2. Assignment to the urgent category may be requested by the applicant, his legally responsible relative, or primary caregiver. The urgent category shall be assigned only when the applicant (who shall have met all of the waiver's level of care criteria), the applicant's spouse, or the parent (either natural, adoptive or foster), or the person who has legal decision-making authority for an individual who is a minor child would accept the requested service if it were offered. The urgent category list criteria shall be as follows:	B.2. Assignment to the urgent category may be requested by the applicant, his legally responsible relative, or primary caregiver. The urgent category shall be assigned only when the applicant (who shall have first met all of the waiver's level of care criteria), the applicant's spouse or parent (either natural, adoptive, or foster), or the person who has legal decision-making authority for an individual who is a minor child would accept the requested service if it were offered. The urgent category list criteria shall be as follows:	Addition of "first" to emphasize that the individual must meet the LOF criteria prior to being considered for assignment to the urgent category.
94.	B.2.f.(3) The case manager shall notify the individual in writing within 10 business days of receiving DBHDS' notification that he has been placed on the Statewide ID Waiting List-Urgent and of his appeal rights.	Addition of requirement that the individual be notified by the case manager of placement on the Statewide Waiting List and offered appeal rights within 10 business days.